STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00		COMPL	ETED
			A. BUILDING 05/09/2011			2013	
			B. WIN	_		20,00	
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					IOORES PIKE ROAD		
AUTUMN	HILLS ALZHEIME	R'S SPECIAL CARE CENTER		BLOOM	MINGTON, IN 47401		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWIDERIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
R000000							
	This visit was f	or a State Residential	ROO	00000	REQUEST FOR PAPER		
			Koc	0000	COMPLIANCE: Autumn Hills		
	Licensure Surv	ey.			Alzheimer's Special Care		
					Center respectfully requests		
	This visit include	ded the Investigation of			consideration for paper		
	Complaint IN00	0124832.			compliance for survey event	id	
					UZIY11 which includes	iu	
	Complaint IN00	0124832 -			deficiency number R0036 an	d	
	•	State Residential			R0349. Thank you for your	u	
					consideration in this importa	ınt	
	finding related to allegations are cited				matter. This plan of correct		
	at R0036 and F	₹0349.			is to serve as Autumn Hills	1011	
					Alzheimer's Special Care		
	Survey dates: I	May 8th and 9th, 2013.			Center's credible allegation	of	
	-	•			compliance. Submission of		
	Facility number	r: 012706			this plan of correction does		
	Provider numb				constitute an admission by		
					Autumn Hills Alzheimer's		
	AIM number: N	V/A			Special Care Center or it's		
					management company that t	he	
	Survey team:				allegations contained in the		
	Susan Worsha	m, RN-TC			survey report are a true and		
	Cheryl Mabry,	RN			accurate portrayal of the		
	Diana McDona				provision of nursing care an	d	
		, - ···			other services in this facility		
	Census bed typ	ne:			Nor does this submission		
	, ,	•			constitute an agreement or		
	Residential: 38	Ď.			admission of the survey		
	Total: 38				allegations.		
	Census payor	type:					
	Other: 38						
	Total: 38						
	. 0.01. 00						
	Commiss 00						
	Sample: 06						
	These state fin	dings are cited in					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGI				E	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Page 1 of 9 State Form Event ID: UZIY11 Facility ID: 012706 If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS ALZHEIMER'S SPECIAL CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETIC TAG COMPLETIC DATE	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC A. BUILDING B. WING	00		LETED 9/2013
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION COMPLETION FOR SHOULD BE COMPLETIC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE				3203 M	OORES PIKE ROAD	ODE	
	PREFIX	(EACH DEFICIEN REGULATORY OF	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SH	HOULD BE	COMPLETION
Quality Review completed on May 16, 2013; by Kimberly Perigo, RN.		Quality Review	v completed on May 16,				

State Form Event ID: UZIY11 Facility ID: 012706 If continuation sheet Page 2 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	ΓΕ SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	COMPLETED	
			B. WIN			05/09/	2013	
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				OORES PIKE ROAD			
AUTUMN	I HILLS ALZHEIME	R'S SPECIAL CARE CENTER			INGTON, IN 47401			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
TAG R000036	410 IAC 16.2-5-1 Residents' Rights (k) The facility muresident 's physical legal representation noticed: (1) a significant of physical, mental, (2) a need to alter that is, a need to form of treatment consequences or of treatment. Based on record interview, the frimmediately information physician and lafter a fall which treatment. (Refindings included Resident #A's or reviewed on Markey in the second of the swalker, as friends and from the second of the swalker, as friends. Nurses notes of the sidents of the sident walker, as friends.	2.2(k)(1-2) 3- Deficiency 4- Deficiency 4- Immediately consult the 4- Cian and the resident 's 5- Ve when the facility has 6- Becline in the resident 's 6- Proposed of the status; or 6- Treatment significantly, 7- Proposed of the status; or 7- Treatment significantly, 8- Commence an existing 9- Commence and 1- Commen	ROO	00036	R036 410 IAC 16.2-5-1.2(k)(1-Resident's Rights-Deficiency It is the practice of Autumn Hill Alzheimer's Special Care Cento immediately inform a reside physician and legal representa after a fall which requires meditreatment. I. RN has been re-educated on the facility's policy regarding informing the resident's physician and legal representative after a fall which requires medical treatment. II. The facility realizes other residents have the potential to affected. This has been addressed by the systems described below.	ds ter nt's titive ical	DATE 06/08/2013	

State Form Event ID: UZIY11 Facility ID: 012706 If continuation sheet Page 3 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	a. Building 00			COMPLETED	
			B. WIN			05/09/	/2013	
NAME OF A	DROWNER OF GUIDE TE	D		_	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	K		3203 M	OORES PIKE ROAD			
AUTUMN	N HILLS ALZHEIME	ER'S SPECIAL CARE CENTER		BLOOM	/INGTON, IN 47401			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL PLICE IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE	
		oom #36 with his walker						
		the doorway and had to to a wheelchair."						
	i ne assisted ini	o a wneelchaif.			III. As noted in the survey rep			
	Intonious	CNA #2 on May 00			the facility has a policy regard	ding		
		CNA #2 on May 09, a.m., indicated that			immediately informing a resident's physician and lega	ı		
		who has since moved			representative after a fall whi			
	•	formed her (CNA #2)			requires medical treatment.			
		CNA) was walking			Licensed facility personnel ha			
	,	ent #A when he			been re-educated on this poli including the importance of	су		
		o into his room and hit			immediately notifying a reside	ent's		
		nis walker, causing him			physician and legal represent			
		e. She (other CNA)			after a fall which requires me			
		hold him up and			treatment. Additional systemi			
		the floor and called for			changes are being implemen through our quality improvem			
		ses notes do no reflect			program as indicated below.			
		ent by the nurse other						
		n ice pack on the						
		t ankle and giving			IV. The HSD or her designee	ie		
	_	Tylenol. She did			completing quality improvement			
		esident #A appeared to			audits of documentation of th			
		of his right lower leg.			immediate notification of			
	20 p. 0.000.140 (7 rigitt 10 ff 01 10 g.			physicians and legal representatives after a fall wh	vioh		
	There is no do	cumentation to indicate			representatives after a fail wr requires medical treatment. T			
		ed Resident #A's family			audits will be performed for 1			
		in, after the fall.			of residents who experience	a fall		
	11 11 2 2 1 3 5 1 5 1 5 1	,			for 60 days, then 50% of	-11		
	The next notat	ion on the chart was at			residents who experience a far for 6 months. Results of all	all		
		, by the morning nurse.			audits will be reported month	ly to		
		more documentation			the facility's Administrator and	-		
		id shift nurse came on			designated QI team for additi			
		Record review of those			recommendations if necessar	ry.		
		d that Resident's wife						
		ne will not tolerate or						
		. However, after			COMPLETION DATE: 6/8/13	i		

State Form Event ID: UZIY11 Facility ID: 012706 If continuation sheet Page 4 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED	
			B. WIN			05/09/	/2013	
			B. WII		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIEF	R			OORES PIKE ROAD			
ΔΗΤΗΜΝ	I HII I S AI 7HEIME	R'S SPECIAL CARE CENTER			IINGTON, IN 47401			
				BLOOM				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
		plaints of discomfort,						
		ordered an X-ray, which						
	was done on 2	/21/13 at 11:00 a.m.						
	Review of X-ra	y results dated 2/21/13						
	indicated a righ							
	_	sident #A was then						
	_	a local acute care						
		lirect admit to an						
	Orthopedic Su							
	Orthopedic 3u	rgeon.						
	Deview of facil	itula Fall Assassment						
		ity's Fall Assessment						
	policy, provide	-						
		a resident falls, the						
		ow the procedure						
	outlined in the	Fall Management						
	Policy and noti	fy the physician and						
	family, as well	as place the resident						
	on alert chartin	ig and on the 24 hour						
	report sheet.	3						
	Interview with	the DON 5/9/13 at						
		licated those forms						
		ound. Documentation						
		sident A's family and						
		immediately been						
	notified after th	ne fall on 2/19/13, was						
	not provided.							
	This Residentia	al finding relates to						
	Complaint IN0	•						
	- p							

State Form Event ID: UZIY11 Facility ID: 012706 If continuation sheet Page 5 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 05/09/2013				
	PROVIDER OR SUPPLIER	R'S SPECIAL CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3203 MOORES PIKE ROAD BLOOMINGTON, IN 47401					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			

State Form Event ID: UZIY11 Facility ID: 012706 If continuation sheet Page 6 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPL	ETED	
			B. WING			05/09/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				OORES PIKE ROAD		
AUTUMN	HILLS ALZHEIME	R'S SPECIAL CARE CENTER		l	MINGTON, IN 47401		
					T		(7/5)
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BEITELE (CT)		DATE
R000349	410 IAC 16.2-5-8 Clinical Records -	. , . ,					
		ust maintain clinical records					
	• ,	These records must be					
		the supervision of an					
		acility designated with that					
	•	e records must be as					
	follows:						
	(1) Complete.						
	(2) Accurately do (3) Readily acces						
	(4) Systematically						
	Based on reco	_	ROO	0349			06/08/2013
		acility failed to ensure	100	70347	R349 410 IAC 16.2-5-8.1(a)(1-	4)	00/00/2013
		in the clinical record			Clinical Records -	-,	
					Noncompliance		
	•	and accurate for 1 of 6			·		
	residents. (Res	sident #A)					
	Findings includ	e:			It is the practice of Autumn Hil	ls	
					Alzheimer's Special Care Cen		
	The clinical rec	ord of Resident # A			to ensure documentation in the	е	
	was reviewed o	on 5/8/13 at 2:02 p.m.			clinical record is complete,		
		•			accurately documented, readil accessible and systematically	y	
	The nurses not	es dated 2/19/13 at			organized.		
		cated Resident #A was			organizoa.		
		assistance to go into					
		ht his walker on the					
					I. RN has been re-educated or		
	-	imbled, and had to be			the importance of documenting		
		wheelchair. The			the clinical record a complete		
		acked documentation			accurate accounting of nursing services including falls	9	
	which indicated	d a fall.			assessments per the facility		
					policy on Falls Management.		
	Interview with 0	CNA #2 on 5/9/10:50]		
	a.m., indicated	that the CNA in the					
	report no longe	er worked there, but			l		
		er (CNA #2) that she			II. The facility realizes other	h a	
		as walking behind the			residents have the potential to	pe	
	(3				affected. This has been		

State Form Event ID: UZIY11 Facility ID: 012706 If continuation sheet Page 7 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIJII DING 00			COMPLETED	
			A. BUILDING B. WING 05/09/2013			2013	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
ALITLIMAN		DIS SDECIAL CADE CENTED			OORES PIKE ROAD		
AUTUMN	N HILLS ALZHEIME	R'S SPECIAL CARE CENTER		BLOOK	MINGTON, IN 47401		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		his walker hit the door			addressed by the systems		
	frame, the resi	dent stumbled back,			described below.		
	and she eased	I him to the floor. She					
	(other CNA) al	so indicated that the					
	resident was m	nuch larger than the			III. Licensed nurses have beer	า	
		NA called out for help			re-educated regarding the		
		to move the resident.			importance of ensuring comple		
		to move the recident.			and accurate documentation t	hat	
	The nurses no	tes do no reflect any			is readily accessible and		
		the nurse other than			systematically organized according to the facility Falls		
					Management policy. Additiona	al	
		pack on the resident's			systemic changes are being	a.	
	right ankle and giving resident some				implemented through an audit		
	1 -	did indicate that			program as indicated below.		
	Resident #A a	•					
	protective of hi	s right lower leg.					
					IV. The HSD or her designee i	s	
		e's documentation was			completing audits of Falls		
		2/20/13 at 6:00 a.m.			Management documentation t	0	
		locumentation was			ensure that the medical record	d is	
	indicated on 2/	20/13 at 2:00 p.m.			a complete and accurate		
					reflection of the provision of		
	Review of facil	ity's Fall Assessment			nursing services following a fa A random sample of licensed	III.	
	policy, provide	d by the DON,			nurses will be observed weekl	v	
	indicated wher	a resident falls, the			for 4 weeks, then every other	J	
		ow the procedure			week for 4 weeks, then month	ly	
		Fall Management			for 6 months. Results of all au	dits	
		fy the physician and			will be reported to the facility		
	_	as place the resident			Administrator and designated	Ql	
	· ·	ng and on the 24 hour			team monthly for additional	,	
		ig and on the 24 noul			recommendations if necessary	y -	
	report sheet.						
	Interview with	the DON on 5/0/42 of					
		the DON on 5/9/13, at			COMPLETION DATE: 6/8/13		
		licated that a resident					
		it is done when a					
	resident falls, b	out one was not done					

State Form Event ID: UZIY11 Facility ID: 012706 If continuation sheet Page 8 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPL - 05/09/	ETED
NAME OF PROVIDER OR SUPPLIER AUTUMN HILLS ALZHEIMER'S SPECIAL CARE CENTER			3203 M	ADDRESS, CITY, STATE, ZIP CO OORES PIKE ROAD MINGTON, IN 47401	DE TOTAL	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	with the DON i looked in the c there was no d fall or a follow per the facility's	1:45 a.m., interview ndicated that after she hart, she indicated that locumentation for the up assessment sheet, s policy and procedure.				

State Form Event ID: UZIY11 Facility ID: 012706 If continuation sheet Page 9 of 9